Reset Form

COMPLAINT FORM

Mail to:

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
P. O. BOX 1157
RICHMOND, VIRGINIA 23218
FAX NUMBER – (804) 371-9349

NAME_____Telephone No. (Include Area Code)

ADDRESS_____Home _____

CITY/ST_____ZIP_____ Office _____

I WISH TO FILE A COMPLAINT: (Please Print)

1. Complaint is against: (Complete a. or b.)

   a. My insurance company—Name:_____

      Agent's name:_____

      Address or tele. no.:_____

      Policy no.:_____

   b. Other party's insurance company—Name:_____

      Other party's name:_____

      Policy or claim no.:_____

2. Date of loss:_____

3. Details of my complaint: (Please type, print or write clearly)

   Please use a separate sheet to provide details.

I am enclosing copies of any correspondence or other papers relating to this matter which I feel would help your investigation of the complaint. I understand that a copy of this form and any or all of the enclosed information may be sent to the party complained against. I also agree that by signing this form I authorize the Bureau of Insurance to obtain any information required to evaluate my complaint.

DATE:_____SIGNED:_____